| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 085006 | A. BUILDING _____ B. WING _____ | C 06/22/2011 |

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| REGAL HEIGHTS HEALTHCARE & REHAB CENTER | 6525 LANCASTER PIKE HOCKESSIN, DE 19707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced annual and complaint survey was conducted at this facility from June 15, 2011 through June 22, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 166. The Stage II survey sample totaled thirty-six (36) residents. | F 000 | | |
| F 156 SS=B | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) | F 156 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rhonda Sinclair — TITLE: Administrator — (X6) DATE: 7-14-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 156 | Continued From page 1<br>(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance | F 156 | | |

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| F 156 | Continued From page 2<br>directives requirements.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview it was determined that the facility failed to post written information on Medicare, Medicaid, and Reporting of Nursing Home Abuse. Findings include:<br><br>Observations from 6/15/11 through 6/22/11 revealed that the facility failed to have information | F 156 | 08/24/2011<br>F 156<br><br>There were no residents negatively affected by this deficiency<br><br>All signs in regards to written notification pertaining to Medicare, Medicaid, Medicaid fraud control, and reporting nursing home abuse have been hung.<br><br>All staff will be in-serviced on placement of signs.<br><br>Audits will be conducted by the receptionist on a monthly basis to ensure signs are continually hung.<br><br>Results of audits will be reviewed by the QA committee | |

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| F 156 | Continued From page 3<br>regarding Medicare, Medicaid, Medicaid fraud control, and Reporting Nursing Home Abuse posted.<br><br>An interview on 6/15/11 with E1 (Administrator) confirmed these findings. E1 stated that the facility did not have these postings available. | F 156 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and orderly interior. Findings include:<br><br>1. An observation on 6/17/11 of R52's room revealed that the pull cord for the over bed light was missing.<br><br>An interview on 6/17/11 with E14 (Maintenance Director) confirmed this finding.<br><br>2. An observation on 6/17/11 of R122's wheelchair revealed a damaged seat pad. The damaged pad was not cleanable.<br><br>3. An observation on 6/17/11 of R148's wheelchair revealed dried food spills.<br><br>4. An observation on 6/17/11 in the laundry room | F 253 | F253<br><br>There were no residents negatively affected by this deficiency<br><br>Resident #52's pull cord was immediately replaced on 6/17/11. Resident #122's wheel chair pad was replaced. Resident #148's wheelchair was cleaned.<br><br>Laundry room ceiling tiles were replaced on 6/17/11, the E Wing shower stall loose wall plate was repaired and the B Wing toilet was immediately cleaned on 6/17/11.<br><br>All staff will be in-serviced on maintaining sanitary, orderly and comfortable interior.<br><br>Audits will be conducted during housekeeping/maintenance rounds on a weekly basis to ensure all areas of housekeeping and maintenance services are in compliance.<br><br>Audit results will be presented to the QA committee | 08/24/2011 |

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| F 253 | Continued From page 4<br>revealed stained ceiling tiles and a suspended ceiling vent that was not fastened securely to the tile above a washer.<br><br>An interview on 6/17/11 with E14 confirmed these findings.<br><br>5. An observation on 6/17/11 of the E Wing shower stall revealed that a wall face plate was loose.<br><br>An interview on 6/17/11 with E14 confirmed this finding.<br><br>6. An observation on 6/17/11 of the B Wing shower area revealed that a toilet was stained brown in color. | F 253 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than | F 278 | | |

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| F 278 | Continued From page 5<br>$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews, it was determined that the MDS (Minimum Data Set) assessment for 4 (R27, R115, R169 and R85) of 36 sampled residents, failed to accurately reflect the resident's status. Findings include:<br><br>1. Review of R27's care plan indicated that she had a fall on 12/11/10. Review of R27's Annual MDS (Minimum Data Set) Assessment, dated 12/17/10, revealed that the facility failed to accurately code for a fall with no injury.<br><br>Findings were confirmed with E7 (Nurse Manager) during an interview on 6/21/11 at 10:53 AM.<br><br>2. Review of R115's OT (Occupational Therapy) evaluation and "Resident Range of Motion Quarterly Comparison", both dated 10/8/10, indicated that R115 had contractures of the left shoulder, left elbow and left wrist/hand. Review of R115's Quarterly MDS, dated 3/31/11 and Annual MDS, dated 6/14/11, revealed that the facility failed to accurately code R115's "Functional Limitation in Range of Motion." | F 278 | F 278<br><br>There were no residents negatively affected by this deficiency<br><br>The MDS corrections for resident's #R27, R115, R169, R85 were completed.<br>Resident R169's PASSAR state a diagnosis of history of Schizophrenia. Care Plan and MDS updated to reflect a diagnosis of history or Schizophrenia.<br><br>RNAC will audit and compare chart documentation to the MDS coding in accordance with MDS schedule with random audit conducted to ensure accuracy.<br><br>RNAC, Director of Restorative and Dietitian were in-serviced on MDS coding and documentation. All other staff will in-serviced on MDS coding and documentation.<br><br>Audits will conducted monthly by the RNAC to Ensure compliance.<br><br>Audit results will be presented to the QA committee<br><br>and updated if necessary.<br><br>All licensed staff will be re-in serviced on creating and updating resident care plans<br><br>Audits will be conducted monthly x's 4 months to Ensure resident care plans are created and updated appropriately and accurately<br><br>Results of audits will be reviewed by the QA committee | 8/24/2011 |

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| F 278 | Continued From page 6<br><br>During an interview on 6/21/11 at 12:10 PM, E7 confirmed that the MDS should have been coded a "1" (impairment on one side) for her upper extremity. E7 stated that R115 does not receive range of motion due to her refusals and complaints of pain and referred to the PT (Physical Therapist) note, dated 10/7/10 in her clinical record.<br><br>3A. R169 had a Pre Admission Screening/Annual Resident Review (PASSAR) completed in 6/10 which stated that the resident had a diagnosis of Schizophrenia. Review of R169's Minimum Data Set (MDS) Assessments dated 12/9/10 (quarterly), 2/22/11 (quarterly) and 5/11/11 (annual) revealed that the facility failed to code an active diagnosis of Schizophrenia.<br><br>3B. Additionally, R169's Quarterly MDS, dated 2/22/11, failed to code physician visits on 2/14/11 and 2/21/11 when R169 received Psychology services of a Licensed Psychologist during the past 14 days.<br><br>3C. R169's Annual MDS, dated 5/11/11, also failed to code an anti psychotic medication being used in the past 7 days. R169's physician ordered Clozapine (Clozaril), an anti psychotic medication that R169 continued to receive since his admission in 6/10. Review of the 5/11 MAR revealed that R169 received Clozapine 200 mg twice a day for the entire month of May 2011.<br><br>The facility failed to have accurate assessments to reflect R169's status. On 6/22/11 in an interview with E8 (RN Assessment Coordinator/RNAC), she confirmed the coding | F 278 | | |

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| F 278 | Continued From page 7<br>errors on the 12/9/10, 2/22/11, and 5/11/11 MDS assessments for R169.<br><br>4. R85 had a diagnosis of diabetes and her physician originally ordered a NCS (no concentrated sweets), mechanical soft diet on 10/27/10 which continued as an order through the 5/11 and 6/11 physician order sheets. On 6/22/11, an observation of R85 at lunch revealed that she had a no concentrated sweets, mechanical soft diet as ordered.<br><br>Review of the annual MDS, dated 5/23/11, revealed that the facility failed to code that R85 was on a therapeutic diet. On 6/21/11 in an interview with E8 (RNAC), she confirmed the findings. | F 278 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under | F 279 | | |

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| F 279 | Continued From page 8<br>§483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and interview, it was determined that for one (R77) out of 36 residents sampled the facility failed to develop a care plan for an identified need of the resident. Findings include:<br><br>Cross refer, F309<br>R77 was admitted to the facility on 9/15/04. Review of the "Resident Problem List" revealed R77's Problems/Diagnoses included dysphagia (difficulty in swallowing or inability to swallow). The 6/11 monthly physician's order sheet (POS) included the following orders, "Mechanical soft diet w/thin liquids (Aspiration Precautions)," "Resident must be out of bed and supervised at meal times," and "Keep resident head of bed elevated @ angle 45 at all times."<br><br>Review of R77's care plans revealed a lack of care planning for the problem of dysphagia and risk of aspiration. During an interview on 6/21/11 with E6 (Registered Dietitian-RD), she acknowledged there was an order for aspiration precautions for R77 and confirmed the lack of a care plan. | F 279 | F279<br><br>Resident R77's care plan was revised to include aspiration precautions.<br><br>All residents with diagnoses of dysphasia and risk of aspiration will have their care plans reviewed and updated if necessary.<br><br>All licensed staff will be re-in serviced on creating and updating resident care plans<br><br>Audits will be conducted monthly x's 4 months to Ensure resident care plans are created and updated appropriately and accurately<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or | F 280 | | |

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| F 280 | Continued From page 9<br>changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to review and revise the plan of care for 1 (R169) out of 36 Stage II sampled residents. The care plan failed to include one of R 169's diagnosis. Findings include:<br><br>Cross refer F278 examples 3A and 3C<br>Review of R169's Pre Admission Screening/Annual Resident Review (PASSAR) completed in 6/10 revealed that the resident had a diagnosis of Schizophrenia, Bipolar Disorder and MDD (Major Depressive Disorder).<br><br>Review of R169's physician order sheet for 6/11 revealed that he was on medications including an antipsychotic, a mood stabilizer, and an antidepressant all ordered upon admission in | F 280 | 08/24/2011<br>F280<br><br>Resident R169's had no ill effect from this deficiency.<br><br>Resident R 169's PASSAR states a diagnosis of history of Schizophrenia. Care Plan updated to reflect a diagnosis of history of Schizophrenia.<br><br>All licensed staff will be re-in-serviced on creating and updating resident care plans<br><br>Audits will be conducted monthly x's 4 months to insure resident care plans are created and updated appropriately and accurately<br><br>Results of audits will be reviewed by the QA committee | |

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| F 280 | Continued From page 10<br>6/10. In addition, R169 also had a a diagnosis of anxiety.<br><br>R169 had a care plan entitled, "Ineffective Coping R/T (related to) Chronic Bipolar disorder requiring use of antidepressant drug therapy" which was developed on 6/10/10 and last revised 5/10/11 for the "Resident's Needs/Problems". The Needs/Problems section of the care plan failed to include R169's additional diagnosis of Schizophrenia and use of antipsychotic and antianxiety medications in addition to antidepressant therapy.<br><br>On 6/22/11 in an interview with E8 (RNAC) and E9 (LPN), they both confirmed that Schizophrenia was not included in R169's care plan along with the use of antispychotic and antianxiety drug therapy. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, it was determined that for one (R77) out of 36 sampled residents the facility failed to follow physician's orders for aspiration precautions. Findings include: | F 309 | F309<br><br>Resident R77 had no negative outcomes from this deficiency.<br><br>The Resident's bed was adjusted to 45 degree angle during survey process.<br><br>Other residents with the diagnoses of dysphasia will have their care plans reviewed and updated as necessary. The resident will also be monitored to ensure head is at a 45 degree angle when resident is in bed.<br><br>Unit Managers will complete audits for all residents on their unit on a weekly basis.<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 | Continued From page 11<br><br>R77 was admitted to the facility on 9/15/04. Review of the "Resident Problem List" revealed R77's Problems/Diagnoses included dysphagia (difficulty in swallowing or inability to swallow). The 6/11 monthly physician's order sheet (POS) included the following orders, "Mechanical soft diet w/thin liquids (Aspiration Precautions)," "Resident must be out of bed and supervised at meal times, " and "Keep resident head of bed elevated @ angle 45 at all times."<br><br>R77 was observed on 6/20/11 at 2:30 PM lying in bed. Upon entering the room it was observed that the head of the bed was flat and not elevated to a 45 degree angle. R77 was bunching up her pillow to elevate her head while coughing. E5 (nurse) was approached and asked to check the position of R77's bed. E5 later confirmed that the head of R77's bed had not been elevated to a 45 degree angle per physician's orders and stated that she had spoken to the CNA about it. The facility failed to follow physician's orders to elevate the head of R77's bed to a 45 degree angle at all times to minimize the risk of aspiration. | F 309 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced | F 323 | | |

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| F 323 | Continued From page 12<br>by:<br>Based on observations it was determined that the facility failed to maintain an environment free of accident hazards as evidenced by unsecured chemical storage and non posting of caution notices. Findings include:<br><br>1. Observations on 6/20/2011 of the C Wing Shower room revealed the unsecured storage of two 8 oz containers of Aloe One, for external use only. Additionally, observations of the H Wing Shower room revealed the unsecured storage of an 8 oz container of Aloe One.<br><br>2. Observations of the B Wing Shower room at 10:00 AM revealed a pool of water on the floor of the shower room floor. A caution notice was not posted regarding the wet floor.<br><br>This observation was repeated and confirmed on 6/21/2011 with E14 ( Maintenance Director). | F 323 | F323<br><br>There were no residents negatively affected by this deficiency<br><br>All items were removed and trashed during the survey process. A wet floor sign has been placed both on the door of the shower room as well as a free standing wet floor sign placed in the shower room.<br><br>All staff will be in-serviced on maintaining a hazard free environment.<br><br>Audits will be conducted by floor staff during daily rounds to ensure all areas are free of environmental hazards.<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews on 6/15/11 | F 371 | | |

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| F 371 | Continued From page 13<br>in the dietary area, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions. Findings include:<br><br>1. An observation on 6/15/11 of the kitchen ceiling revealed that the suspended and inactive heating unit was soiled with dust and yellow deposits.<br><br>In an interview on 6/15/11 with E12 (Food Service Supervisor), she confirmed these findings.<br><br>2. An observation on 6/15/11 of the food tray carrier revealed that the clean, stacked trays were dripping wet.<br><br>In an interview on 6/15/11 with E12 she confirmed these findings.<br><br>3. An observation on 6/15/11 of the milk cooler revealed that the seal of the opening was in disrepair.<br><br>In an interview on 6/15/11 with E12 she confirmed these findings.<br><br>4. An observation on 6/15/11 of the frying pans on the ready-to-use wall rack revealed that five (5) Teflon coated pans were chipped.<br><br>In an interview on 6/15/11 with E12 she confirmed these findings and removed the five Teflon pans.<br><br>5. An observation on 6/15/11 of the convection oven and four burner ranges revealed encrusted grease deposits. | F 371 | F371<br><br>There were no residents negatively affected by this deficiency<br><br>All items were cleaned, repaired or discarded during survey process.<br><br>All appropriate staff will be in-serviced on safe food procure storage/prepare/serve and sanitation.<br><br>Weekly audits will be conducted by the Food Service Director to ensure proper procedures are followed.<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |

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| F 371 | Continued From page 14<br>In an interview with E12 she confirmed these findings. E12 stated that the convection oven was cleaned weekly.<br><br>6. An observation on 6/15/11 of the paper storage room revealed that a stack of Styrofoam cups was uncovered.<br><br>In an interview on 6/15/11 with E12 she confirmed these findings and she covered the stack of cups.<br><br>7. An observation on 6/15/11 of the ice machine revealed that the drain pipe was in close proximity of the floor drain and failed to include an air gap.<br><br>In an interview on 6/15/11 with E13 (District Manager of Food Services), he confirmed the absence of a two pipe diameter air gap. | F 371 | | |
| F 431 SS=B | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. | F 431 | | |

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| F 431 | Continued From page 15<br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, it was determined that the facility failed to ensure that the drugs and biologicals stored in the medication rooms and medication carts were not expired and that medication refrigerators were free of food products. Findings include:<br><br>1.An observation on 6/20/11 of the C Wing medication cart revealed (1) open 16 ounce bottle of Apap Elixir (Generic Tylenol) which had expired on 4/10/11.<br><br>Immediately after the observation on 6/20/11, E5 (LPN) confirmed the findings and she removed the medication from the cart.<br><br>2.An observation on 6/20/11 of the E Wing medication cart revealed (1) open bottle of | F 431 | F431<br><br>There were no residents negatively affected by this deficiency<br><br>All expired medications were discarded during the survey process.<br>All food was discarded from the B wing medication refrigerator during the survey process.<br><br>All staff will be re-in-serviced to ensure the proper storage of medications and biological, as well as proper disposal of expired medications and the medication refrigerators will be free of food products.<br><br>Audits will be conducted weekly by the Unit Manager to ensure proper storage of medications and biological, as well proper disposal of expired medications, as the medication refrigerators being free of food.<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |

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| F 431 | Continued From page 16<br>Ranitidine (Acid Reducer) 75mg tablets that expired on 5/10/11 and (1) open bottle of Aspirin EC (enteric coated) 325mg tablets that expired on 3/11/11.<br><br>E9 (LPN) confirmed these findings immediately after the observation on 6/20/11 and removed the medication from the cart.<br><br>3.An observation on 6/20/11 of the H Wing medication cart revealed (1) open bottle of Tylenol Extra Strength 500mg tablets that expired on 4/11/11.<br><br>E10 (LPN) confirmed the findings immediately after the observation on 6/20/11 and removed the medication from the cart.<br><br>4. Observation on 6/20/11 of the B Wing medication refrigerator in the medication storage room revealed there was a plastic container of food and (4) cartons of milk.<br><br>In an interview with E11(LPN) on 6/20/11 immediately after the observation, E11 confirmed these findings and stated that she did not know to whom these food items belonged. E11 acknowledged that the food items should not be stored in the same refrigerator as medications and biologicals and she removed the items from the medication refrigerator. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission | F 441 | | |

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| F 441 | Continued From page 17<br>of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, it was determined that the facility failed to maintain infection control practices designed to provide a | F 441 | F 441<br><br>There were no residents negatively affected by this deficiency<br><br>Employees noted in the deficiency were in-serviced on proper hand washing and the administration of eye drops.<br><br>All staff will be re-in-serviced on the Centers for Disease Control recommendations for Hand Hygiene in a health care setting and the administration of eye drops policy and procedure.<br><br>Audits will be conducted weekly by the Unit Manager to ensure hand washing procedures are being followed, as well as monitoring the administration of eye drops.<br><br>Results of audits will be reviewed by the QA committee | 08/24/2011 |

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| F 441 | Continued From page 18 | F 441 | | |

safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection for two (R53) & (R30) out of 36 sampled residents. Findings include:

The CDC (Centers for Disease Control) recommendations for Hand Hygiene in Health-Care Settings states, "2. Hand-hygiene technique... When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet (IB)" (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm)

1. On 6/21/11, E4 (nurse) was observed providing wound care for R30. Upon completion of the wound care E4 washed his hands, turned the left faucet off with his bare, wet left hand turned the faucet back on, rinsed his left hand and then turned off the faucet with the paper towel. E4 did not re-wash his hands. E4 acknowledged that he failed to use a paper towel to turn off the faucet after first washing his hands.

2. An observation on 6/15/11 of E5 (LPN) during medication administration revealed that, E5 (LPN) put on a pair of gloves during medication preparation. E5 removed the gloves and failed to wash her hands before putting on another pair of gloves to administer eye drops to R53. While administering eye drops to R53, E5 incorrectly used the same tissue to blot both eyes. After

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| F 441 | Continued From page 19<br>medications were given, E5 washed her hands and dried them on a paper towel. E5 used the paper towel to turn off the faucet, then redried her hands using the contaminated paper towel.<br><br>An interview on 6/15/11 with E5 immediately after the observation, confirmed that E5 did not follow infection control practices and facility policy for hand washing and the administration of eye drops.<br><br>A review of the facilities policy entitled Instillation of Eye Drops states, "..... Use only one tissue per wipe." | F 441 | | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations it was determined that the facility failed to maintain a communication system for the shower and bathing areas. Findings include:<br><br>A observation on 6/20/11 of the B Wing shower room revealed that a call alarm was not accessible to the shower and bathing areas. Additionally, the toilet was inaccessible due to the storage of shower chairs. | F 463 | F 463<br><br>There were no residents negatively affected by this deficiency<br><br>Shower chairs were removed during the survey process. Proper call bell system was installed.<br><br>All staff will be re-in-serviced on the proper storage of equipment blocking a call light system.<br><br>Audits will be conducted weekly by the Unit Manager to ensure equipment is not blocking a call light system.<br><br>Results of audits will be reviewed by the QA committee. | 08/24/2011 |

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT



NAME OF FACILITY: Regal Heights

DATE SURVEY COMPLETED: June 22, 2011

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---|---|---|
| | An unannounced annual and complaint survey was conducted at this facility from June 15, 2011 through June 22, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 166. The survey Stage II sample totaled thirty-six (36) residents. | |
| 3201 | **Regulations for Skilled and Intermediate Care Facilities** | |
| 3201.1.0 | **Scope**<br><br>**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross refer to the CMS 2567-L survey report date completed 6/22/11, F156, F253, F278, F279, F280, F309, F323, F371, F431, F441, and F463. | Cross-refer to POC for CMS 2567-L survey F-tag 156, 253, 278,279,280,309,323,371,431,441 and 463 |

Provider's Signature Rhonda Duncan Title Administrator Date 7-14-11